each other's countries. This is something that will both help the U.S. economy as a major exporter, but also help our growth going forward. So, we need to work more closely. Specifically, this bill authorizes financing for private-sector investments both in energy security projects in the United States and likewise in the trade that will ensue in renewables.

Mr. Speaker, I want to thank the committee for taking such early action in this Congress. I think it states the priority nature of this, knowing that this is going to be something that enhances European security, our security, enhances our economy and theirs, and seeks to protect us. Because as they talk about projects like Nord Stream 2 in Germany, they are using right now that leverage to create a threat and to isolate countries like Ukraine from their basic energy economic development.

This is important in so many respects. I urge my colleagues on both sides of the aisle, showing the leadership of this bipartisan bill, to move it forward quickly.

I also want to recognize, again, Senator MURPHY who has been such a leader of this on the Senate side. It is rare that we have such strong bipartisan support for a bill, as well as bicameral support. Let's go ahead and move this forward today.

Mr. ROONEY of Florida. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would once again like to thank the authors of this important bill, Mr. KINZINGER and Mr. KEATING, as well as Chairman SIRES for his support, and I am glad to know that Senator MURPHY is on the case as well.

One more time, I would just like to say, if I might, what a terrible idea the Nord Stream 2 pipeline is, and I appreciate the strong comments that Congressman KEATING just made. We should be opposing that, and we should be supporting the Trans-Caucasus pipeline to get more oil into Eastern Europe, away from Russia, and out of the bondage of their control of the pipelines.

So, I would like to thank the authors one more time and encourage all our colleagues to support this important bill, and I yield back the balance of my time.

Mr. SIRES. Mr. Speaker, I yield myself such time as I may consume. I want to thank, again, Mr. KINZINGER and Mr. KEATING for their work on this bill to bolster our allies in the face of Russian pressure.

This is a good measure that addresses Russia's use of energy to exploit and blackmail countries around the world, and I urge my colleagues to support it.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SIRES) that the House suspend the rules and pass the bill, H.R. 1616, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. SIRES. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

MEDICAID SERVICES INVESTMENT AND ACCOUNTABILITY ACT OF 2019

Mr. RUIZ. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1839) to amend title XIX to extend protection for Medicaid recipients of home and community-based services against spousal impoverishment, establish a State Medicaid option to provide coordinated care to children with complex medical conditions through health homes, prevent the misclassification of drugs for purposes of the Medicaid drug rebate program, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1839

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicaid Services Investment and Accountability Act of 2019''.

SEC. 2. EXTENSION OF PROTECTION FOR MEDICAID RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

(a) IN GENERAL.—Section 2404 of Public Law 111–148 (42 U.S.C. 1396r–5 note), as amended by section 3(a) of the Medicaid Extenders Act of 2019 (Public Law 116–3), is amended by striking ''March 31, 2019'' and inserting ''September 30, 2019''.

(b) RULE OF CONSTRUCTION.—

(1) PROTECTING STATE SPOUSAL INCOME AND ASSET DISREGARD FLEXIBILITY UNDER WAIVERS AND PLAN AMENDMENTS.—Nothing in section 2404 of Public Law 111–148 (42 U.S.C. 1396r–5 note) or section 1924 of the Social Security Act (42 U.S.C. 1396r–5) shall be construed as prohibiting a State from disregarding an individual's spousal income and assets under a State waiver or plan amendment described in paragraph (2) for purposes of making determinations of eligibility for home and community-based services or home and community-based attendant services and supports under such waiver or plan amendment.

(2) STATE WAIVER OR PLAN AMENDMENT DESCRIBED.—A State waiver or plan amendment described in this paragraph is any of the following:

(A) A waiver or plan amendment to provide medical assistance for home and community-based services under a waiver or plan amendment under subsection (c), (d), or (i) of section 1915 of the Social Security Act (42 U.S.C. 1396n) or under section 1115 of such Act (42 U.S.C. 1315).

(B) A plan amendment to provide medical assistance for home and community-based services for individuals by reason of being determined eligible under section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10)(C)) or by reason of section 1902(f) of such Act (42 U.S.C. 1396a(f)) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care under which the State disregarded the income and assets of the individual's spouse in determining the initial and ongoing financial eligibility of an individual for such services in place of the spousal impoverishment provisions applied under section 1924 of such Act (42 U.S.C. 1396r–5).

(C) A plan amendment to provide medical assistance for home and community-based attendant services and supports under section 1915(k) of such Act (42 U.S.C. 1396n(k)).

SEC. 3. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR CHILDREN WITH MEDICALLY COMPLEX CONDITIONS.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1945 the following new section:

''SEC. 1945A. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR CHILDREN WITH MEDICALLY COMPLEX CONDITIONS.

''(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability), beginning October 1, 2022, a State, at its option as a State plan amendment, may provide for medical assistance under this title to children with medically complex conditions who choose to enroll in a health home under this section by selecting a designated provider, a team of health care professionals operating with such a provider, or a health team as the child's health home for purposes of providing the child with health home services.

''(b) HEALTH HOME QUALIFICATION STANDARDS.—The Secretary shall establish standards for qualification as a health home for purposes of this section. Such standards shall include requiring designated providers, teams of health care professionals operating with such providers, and health teams to demonstrate to the State the ability to do the following:

''(1) Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times.

''(2) Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences.

''(3) Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into such child's care plan, in a manner consistent with the needs of the child and the choices of the child's family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care.

''(4) Coordinate access to—

''(A) subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary; and

''(B) palliative services if the State provides such services under the State plan (or a waiver of such plan).

''(5) Coordinate care for children with medically complex conditions with out-of-State providers furnishing care to such children to the maximum extent practicable for the families of such children and where medically necessary, in accordance with guidance issued under subsection (e)(1) and section 431.52 of title 42, Code of Federal Regulations.

''(6) Collect and report information under subsection (g)(1).

''(c) PAYMENTS.—

''(1) IN GENERAL.—A State shall provide a designated provider, a team of health care professionals operating with such a provider,

or a health team with payments for the provision of health home services to each child with medically complex conditions that selects such provider, team of health care professionals, or health team as the child's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 2 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be increased by 15 percentage points, but in no case may exceed 90 percent.

''(2) METHODOLOGY.—

''(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

''(i) may be tiered to reflect, with respect to each child with medically complex conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, the severity or number of each such child's chronic conditions, life-threatening illnesses, disabilities, or rare diseases, or the specific capabilities of the provider, team of health care professionals, or health team; and

''(ii) shall be established consistent with section 1902(a)(30)(A).

''(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

''(3) PLANNING GRANTS.—

''(A) IN GENERAL.—Beginning October 1, 2022, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

''(B) STATE CONTRIBUTION.—A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

''(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed $5,000,000.

''(d) COORDINATING CARE.—

''(1) HOSPITAL NOTIFICATION.—A State with a State plan amendment approved under this section shall require each hospital that is a participating provider under the State plan (or a waiver of such plan) to establish procedures for, in the case of a child with medically complex conditions who is enrolled in a health home pursuant to this section and seeks treatment in the emergency department of such hospital, notifying the health home of such child of such treatment.

''(2) EDUCATION WITH RESPECT TO AVAILABILITY OF HEALTH HOME SERVICES.—In order for a State plan amendment to be approved under this section, a State shall include in the State plan amendment a description of the State's process for educating providers participating in the State plan (or a waiver of such plan) on the availability of health home services for children with medically complex conditions, including the process by which such providers can refer such children to a designated provider, team of health care professionals operating such a provider, or health team for the purpose of establishing a health home through which such children may receive such services.

''(3) FAMILY EDUCATION.—In order for a State plan amendment to be approved under this section, a State shall include in the State plan amendment a description of the State's process for educating families with children eligible to receive health home services pursuant to this section of the availability of such services. Such process shall include the participation of family-to-family entities or other public or private organizations or entities who provide outreach and information on the availability of health care items and services to families of individuals eligible to receive medical assistance under the State plan (or a waiver of such plan).

''(4) MENTAL HEALTH COORDINATION.—A State with a State plan amendment approved under this section shall consult and coordinate, as appropriate, with the Secretary in addressing issues regarding the prevention and treatment of mental illness and substance use among children with medically complex conditions receiving health home services under this section.

''(e) GUIDANCE ON COORDINATING CARE FROM OUT-OF-STATE PROVIDERS.—

''(1) IN GENERAL.—Not later than October 1, 2020, the Secretary shall issue (and update as the Secretary determines necessary) guidance to State Medicaid directors on—

''(A) best practices for using out-of-State providers to provide care to children with medically complex conditions;

''(B) coordinating care for such children provided by such out-of-State providers (including when provided in emergency and non-emergency situations);

''(C) reducing barriers for such children receiving care from such providers in a timely fashion; and

''(D) processes for screening and enrolling such providers in the respective State plan (or a waiver of such plan), including efforts to streamline such processes or reduce the burden of such processes on such providers.

''(2) STAKEHOLDER INPUT.—In carrying out paragraph (1), the Secretary shall issue a request for information to seek input from children with medically complex conditions and their families, States, providers (including children's hospitals, hospitals, pediatricians, and other providers), managed care plans, children's health groups, family and beneficiary advocates, and other stakeholders with respect to coordinating the care for such children provided by out-of-State providers.

''(f) MONITORING.—A State shall include in the State plan amendment—

''(1) a methodology for tracking reductions in inpatient days and reductions in the total cost of care resulting from improved care coordination and management under this section;

''(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider); and

''(3) a methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-State providers.

''(g) DATA COLLECTION.—

''(1) PROVIDER REPORTING REQUIREMENTS.—In order to receive payments from a State under subsection (c), a designated provider, a team of health care professionals operating with such a provider, or a health team shall report to the State, at such time and in such form and manner as may be required by the State, the following information:

''(A) With respect to each such provider, team of health care professionals, or health team, the name, National Provider Identification number, address, and specific health care services offered to be provided to children with medically complex conditions who have selected such provider, team of health care professionals, or health team as the health home of such children.

''(B) Information on all applicable measures for determining the quality of health home services provided by such provider, team of health care professionals, or health team, including, to the extent applicable, child health quality measures and measures for centers of excellence for children with complex needs developed under this title, title XXI, and section 1139A.

''(C) Such other information as the Secretary shall specify in guidance.

When appropriate and feasible, such provider, team of health care professionals, or health team, as the case may be, shall use health information technology in providing the State with such information.

''(2) STATE REPORTING REQUIREMENTS.—

''(A) COMPREHENSIVE REPORT.—A State with a State plan amendment approved under this section shall report to the Secretary (and, upon request, to the Medicaid and CHIP Payment and Access Commission), at such time and in such form and manner determined by the Secretary to be reasonable and minimally burdensome, the following information:

''(i) Information reported under paragraph (1).

''(ii) The number of children with medically complex conditions who have selected a health home pursuant to this section.

''(iii) The nature, number, and prevalence of chronic conditions, life-threatening illnesses, disabilities, or rare diseases that such children have.

''(iv) The type of delivery systems and payment models used to provide services to such children under this section.

''(v) The number and characteristics of designated providers, teams of health care professionals operating with such providers, and health teams selected as health homes pursuant to this section, including the number and characteristics of out-of-State providers, teams of health care professionals operating with such providers, and health teams who have provided health care items and services to such children.

''(vi) The extent to which such children receive health care items and services under the State plan.

''(vii) Quality measures developed specifically with respect to health care items and services provided to children with medically complex conditions.

''(B) REPORT ON BEST PRACTICES.—Not later than 90 days after a State has a State plan amendment approved under this section, such State shall submit to the Secretary, and make publicly available on the appropriate State website, a report on how the State is implementing guidance issued under subsection (e)(1), including through any best practices adopted by the State.

''(h) RULE OF CONSTRUCTION.—Nothing in this section may be construed—

''(1) to require a child with medically complex conditions to enroll in a health home under this section;

''(2) to limit the choice of a child with medically complex conditions in selecting a designated provider, team of health care professionals operating with such a provider, or health team that meets the health home qualification standards established under subsection (b) as the child's health home; or

''(3) to reduce or otherwise modify—

''(A) the entitlement of children with medically complex conditions to early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r)); or

''(B) the informing, providing, arranging, and reporting requirements of a State under section 1902(a)(43).

''(i) DEFINITIONS.—In this section:

''(1) CHILD WITH MEDICALLY COMPLEX CONDITIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'child with medically complex conditions' means an individual under 21 years of age who—

''(i) is eligible for medical assistance under the State plan (or under a waiver of such plan); and

''(ii) has at least—

''(I) one or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or

''(II) one life-limiting illness or rare pediatric disease (as defined in section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3))).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic, life threatening illnesses, disabilities, rare diseases or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

''(2) CHRONIC CONDITION.—The term 'chronic condition' means a serious, long-term physical, mental, or developmental disability or disease, including the following:

''(A) Cerebral palsy.

''(B) Cystic fibrosis.

''(C) HIV/AIDS.

''(D) Blood diseases, such as anemia or sickle cell disease.

''(E) Muscular dystrophy.

''(F) Spina bifida.

''(G) Epilepsy.

''(H) Severe autism spectrum disorder.

''(I) Serious emotional disturbance or serious mental health illness.

''(3) HEALTH HOME.—The term 'health home' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by a child with medically complex conditions (or the family of such child) to provide health home services.

''(4) HEALTH HOME SERVICES.—

''(A) IN GENERAL.—The term 'health home services' means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

''(B) SERVICES DESCRIBED.—The services described in this subparagraph shall include—

''(i) comprehensive care management;

''(ii) care coordination, health promotion, and providing access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-State providers, as medically necessary;

''(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

''(iv) patient and family support (including authorized representatives);

''(v) referrals to community and social support services, if relevant; and

''(vi) use of health information technology to link services, as feasible and appropriate.

''(5) DESIGNATED PROVIDER.—The term 'designated provider' means a physician (including a pediatrician or a pediatric specialty or subspecialty provider), children's hospital, clinical practice or clinical group practice, prepaid inpatient health plan or prepaid ambulatory health plan (as defined by the Secretary), rural clinic, community health center, community mental health center, home health agency, or any other entity or provider that is determined by the State and approved by the Secretary to be qualified to be a health home for children with medically complex conditions on the basis of documentation evidencing that the entity has the systems, expertise, and infrastructure in place to provide health home services. Such term may include providers who are employed by, or affiliated with, a children's hospital.

''(6) TEAM OF HEALTH CARE PROFESSIONALS.—The term 'team of health care professionals' means a team of health care professionals (as described in the State plan amendment under this section) that may—

''(A) include—

''(i) physicians and other professionals, such as pediatricians or pediatric specialty or subspecialty providers, nurse care coordinators, dietitians, nutritionists, social workers, behavioral health professionals, physical therapists, occupational therapists, speech pathologists, nurses, individuals with experience in medical supportive technologies, or any professionals determined to be appropriate by the State and approved by the Secretary;

''(ii) an entity or individual who is designated to coordinate such a team; and

''(iii) community health workers, translators, and other individuals with culturally-appropriate expertise; and

''(B) be freestanding, virtual, or based at a children's hospital, hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity determined to be appropriate by the State and approved by the Secretary.

''(7) HEALTH TEAM.—The term 'health team' has the meaning given such term for purposes of section 3502 of Public Law 111–148.''.

SEC. 4. EXTENSION OF THE COMMUNITY MENTAL HEALTH SERVICES DEMONSTRATION PROGRAM.

Section 223(d)(3) of the Protecting Access to Medicare Act of 2014 (42 U.S.C. 1396a note) is amended by striking ''for 2-year demonstration programs under this subsection'' and inserting ''to conduct demonstration programs under this subsection for 2 years or through June 30, 2019, whichever is longer''.

SEC. 5. ADDITIONAL FUNDING FOR THE MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

Section 6071(h)(1)(F) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended by striking ''$112,000,000'' and inserting ''132,000,000''.

SEC. 6. PREVENTING THE MISCLASSIFICATION OF DRUGS UNDER THE MEDICAID DRUG REBATE PROGRAM.

(a) APPLICATION OF CIVIL MONEY PENALTY FOR MISCLASSIFICATION OF COVERED OUTPATIENT DRUGS.—

(1) IN GENERAL.—Section 1927(b)(3) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(A) in the paragraph heading, by inserting ''AND DRUG PRODUCT'' after ''PRICE'';

(B) in subparagraph (A)—

(i) in clause (ii), by striking ''; and'' at the end and inserting a semicolon;

(ii) in clause (iii), by striking the period at the end and inserting a semicolon;

(iii) in clause (iv), by striking the semicolon at the end and inserting ''; and''; and

(iv) by inserting after clause (iv) the following new clause:

''(v) not later than 30 days after the last day of each month of a rebate period under the agreement, such drug product information as the Secretary shall require for each of the manufacturer's covered outpatient drugs.''; and

(C) in subparagraph (C)—

(i) in clause (ii), by inserting '', including information related to drug pricing, drug product information, and data related to drug pricing or drug product information,'' after ''provides false information'';

(ii) by adding at the end the following new clauses:

''(iii) MISCLASSIFIED DRUG PRODUCT OR MISREPORTED INFORMATION.—

''(I) IN GENERAL.—Any manufacturer with an agreement under this section that knowingly (as defined in section 1003.110 of title 42, Code of Federal Regulations (or any successor regulation)) misclassifies a covered outpatient drug, such as by knowingly submitting incorrect drug product information, is subject to a civil money penalty for each covered outpatient drug that is misclassified in an amount not to exceed 2 times the amount of the difference between—

''(aa) the total amount of rebates that the manufacturer paid with respect to the drug to all States for all rebate periods during which the drug was misclassified; and

''(bb) the total amount of rebates that the manufacturer would have been required to pay, as determined by the Secretary using drug product information provided by the manufacturer, with respect to the drug to all States for all rebate periods during which the drug was misclassified if the drug had been correctly classified.

''(II) OTHER PENALTIES AND RECOVERY OF UNDERPAID REBATES.—The civil money penalties described in subclause (I) are in addition to other penalties as may be prescribed by law and any other recovery of the underlying underpayment for rebates due under this section or the terms of the rebate agreement as determined by the Secretary.

''(iv) INCREASING OVERSIGHT AND ENFORCEMENT.—Each year the Secretary shall retain, in addition to any amount retained by the Secretary to recoup investigation and litigation costs related to the enforcement of the civil money penalties under this subparagraph and subsection (c)(4)(B)(ii)(III), an amount equal to 25 percent of the total amount of civil money penalties collected under this subparagraph and subsection (c)(4)(B)(ii)(III) for the year, and such retained amount shall be available to the Secretary, without further appropriation and until expended, for activities related to the oversight and enforcement of this section and agreements under this section, including—

''(I) improving drug data reporting systems;

''(II) evaluating and ensuring manufacturer compliance with rebate obligations; and

''(III) oversight and enforcement related to ensuring that manufacturers accurately and fully report drug information, including data related to drug classification.''; and

(iii) in subparagraph (D)—

(I) in clause (iv), by striking '', and'' and inserting a comma;

(II) in clause (v), by striking the period and inserting '', and''; and

(III) by inserting after clause (v) the following new clause:

''(vi) in the case of categories of drug product or classification information that were not considered confidential by the Secretary on the day before the date of the enactment of this clause.''.

(2) TECHNICAL AMENDMENTS.—

(A) Section 1903(i)(10) of the Social Security Act (42 U.S.C. 1396b(i)(10)) is amended—

(i) in subparagraph (C)—

(I) by adjusting the left margin so as to align with the left margin of subparagraph (B); and

(II) by striking ``, and'' and inserting a semicolon;

(ii) in subparagraph (D), by striking ``; or'' and inserting ``; and''; and

(iii) by adding at the end the following new subparagraph:

``(E) with respect to any amount expended for a covered outpatient drug for which a suspension under section 1927(c)(4)(B)(ii)(II) is in effect; or''.

(B) Section 1927(b)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(C)(ii)) is amended by striking ``subsections (a) and (b)'' and inserting ``subsections (a), (b), (f)(3), and (f)(4)''.

(b) RECOVERY OF UNPAID REBATE AMOUNTS DUE TO MISCLASSIFICATION OF COVERED OUTPATIENT DRUGS.—

(1) IN GENERAL.—Section 1927(c) of the Social Security Act (42 U.S.C. 1396r–8(c)) is amended by adding at the end the following new paragraph:

``(4) RECOVERY OF UNPAID REBATE AMOUNTS DUE TO MISCLASSIFICATION OF COVERED OUTPATIENT DRUGS.—

``(A) IN GENERAL.—If the Secretary determines that a manufacturer with an agreement under this section paid a lower per-unit rebate amount to a State for a rebate period as a result of the misclassification by the manufacturer of a covered outpatient drug (without regard to whether the manufacturer knowingly made the misclassification or should have known that the misclassification would be made) than the per-unit rebate amount that the manufacturer would have paid to the State if the drug had been correctly classified, the manufacturer shall pay to the State an amount equal to the product of—

``(i) the difference between—

``(I) the per-unit rebate amount paid to the State for the period; and

``(II) the per-unit rebate amount that the manufacturer would have paid to the State for the period, as determined by the Secretary, if the drug had been correctly classified; and

``(ii) the total units of the drug paid for under the State plan in the period.

``(B) AUTHORITY TO CORRECT MISCLASSIFICATIONS.—

``(i) IN GENERAL.—If the Secretary determines that a manufacturer with an agreement under this section has misclassified a covered outpatient drug (without regard to whether the manufacturer knowingly made the misclassification or should have known that the misclassification would be made), the Secretary shall notify the manufacturer of the misclassification and require the manufacturer to correct the misclassification in a timely manner.

``(ii) ENFORCEMENT.—If, after receiving notice of a misclassification from the Secretary under clause (i), a manufacturer fails to correct the misclassification by such time as the Secretary shall require, until the manufacturer makes such correction, the Secretary may do any or all of the following:

``(I) Correct the misclassification, using drug product information provided by the manufacturer, on behalf of the manufacturer.

``(II) Suspend the misclassified drug and the drug's status as a covered outpatient drug under the manufacturer's national rebate agreement, and exclude the misclassified drug from Federal financial participation in accordance with section 1903(i)(10)(E).

``(III) Impose a civil money penalty (which shall be in addition to any other recovery or penalty which may be available under this section or any other provision of law) for each rebate period during which the drug is misclassified not to exceed an amount equal to the product of—

``(aa) the total number of units of each dosage form and strength of such misclassified drug paid for under any State plan during such a rebate period; and

``(bb) 23.1 percent of the average manufacturer price for the dosage form and strength of such misclassified drug.

``(C) REPORTING AND TRANSPARENCY.—

``(i) IN GENERAL.—The Secretary shall submit a report to Congress on at least an annual basis that includes information on the covered outpatient drugs that have been identified as misclassified, any steps taken to reclassify such drugs, the actions the Secretary has taken to ensure the payment of any rebate amounts which were unpaid as a result of such misclassification, and a disclosure of expenditures from the fund created in subsection (b)(3)(C)(iv), including an accounting of how such funds have been allocated and spent in accordance with such subsection.

``(ii) PUBLIC ACCESS.—The Secretary shall make the information contained in the report required under clause (i) available to the public on a timely basis.

``(D) OTHER PENALTIES AND ACTIONS.—Actions taken and penalties imposed under this clause shall be in addition to other remedies available to the Secretary including terminating the manufacturer's rebate agreement for noncompliance with the terms of such agreement and shall not exempt a manufacturer from, or preclude the Secretary from pursuing, any civil money penalty under this title or title XI, or any other penalty or action as may be prescribed by law.''.

(2) OFFSET OF RECOVERED AMOUNTS AGAINST MEDICAL ASSISTANCE.—Section 1927(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r–8(b)(1)(B)) is amended by inserting ``, including amounts received by a State under subsection (c)(4),'' after ``in any quarter''.

(c) CLARIFYING DEFINITIONS.—Section 1927(k) of the Social Security Act (42 U.S.C. 1396r–8(k)) is amended—

(1) in paragraph (2)(A), by striking ``paragraph (5)'' and inserting ``paragraph (4)''; and

(2) in paragraph (7)(A)—

(A) by striking ``an original new drug application'' and inserting ``a new drug application'' each place it appears;

(B) in clause (i), by striking ``(not including any drug described in paragraph (5))'' and inserting ``, including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4),'';

(C) in clause (ii)—

(i) by striking ``was originally marketed'' and inserting ``is marketed''; and

(ii) by inserting ``, unless the Secretary determines that a narrow exception applies (as described in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation))'' before the period; and

(D) in clause (iv)—

(i) by inserting ``, including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4),'' after ``covered outpatient drug'';

(ii) by inserting ``unless the Secretary determines that a narrow exception applies (as described in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation))'' after ``under the new drug application''; and

(iii) by adding at the end the following new sentence: ``Such term also includes a covered outpatient drug that is a biological product licensed, produced, or distributed under a biologics license application approved by the Food and Drug Administration.''.

(d) EXCLUSION OF MANUFACTURERS FOR KNOWING MISCLASSIFICATION OF COVERED OUTPATIENT DRUGS.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

``(17) KNOWINGLY MISCLASSIFYING COVERED OUTPATIENT DRUGS.—Any manufacturer or officer, director, agent, or managing employee of such manufacturer that knowingly misclassifies a covered outpatient drug under an agreement under section 1927, knowingly fails to correct such misclassification, or knowingly provides false information related to drug pricing, drug product information, or data related to drug pricing or drug product information.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act, and shall apply to covered outpatient drugs supplied by manufacturers under agreements under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

SEC. 7. EXTENSION OF THIRD-PARTY LIABILITY PERIOD FOR CHILD SUPPORT SERVICES.

(a) IN GENERAL.—Section 202(a)(2) of the Bipartisan Budget Act of 2013 (Public Law 113–67) is amended by striking ``90 days'' and inserting ``100 days''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of the enactment of this Act.

SEC. 8. DENIAL OF FFP FOR CERTAIN EXPENDITURES RELATING TO VACUUM ERECTION SYSTEMS AND PENILE PROSTHETIC IMPLANTS.

(a) IN GENERAL.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended by inserting after paragraph (11) the following:

``(12) with respect to any amounts expended for—

``(A) a vacuum erection system that is not medically necessary; or

``(B) the insertion, repair, or removal and replacement of a penile prosthetic implant (unless such insertion, repair, or removal and replacement is medically necessary); or''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to items and services furnished on or after January 1, 2020.

SEC. 9. DETERMINATION OF BUDGETARY EFFECTS.

The budgetary effects of this Act, for the purpose of complying with the Statutory Pay-As-You-Go Act of 2010, shall be determined by reference to the latest statement titled ``Budgetary Effects of PAYGO Legislation'' for this Act, submitted for printing in the Congressional Record by the Chairman of the House Budget Committee, provided that such statement has been submitted prior to the vote on passage.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California (Mr. RUIZ) and the gentleman from Texas (Mr. BURGESS) each will control 20 minutes.

The Chair recognizes the gentleman from California.

GENERAL LEAVE

Mr. RUIZ. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material on H.R. 1839.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. RUIZ. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am humbled to rise in support of H.R. 1839, the Medicaid Services Investment and Accountability Act, a bill that will strengthen our healthcare system by putting patients first.

I am an emergency physician, and as a doctor I have treated patients who, because they couldn't afford the care they needed, slipped through the cracks, worsening their quality of life, harming themselves and their families, and sometimes ending up in the emergency department for lifesaving care.

This bill makes five essential reforms to Medicaid that put patients first, helping children and individuals with mental health issues access the care that they need.

The bill's first reform reflects the hard work and tireless efforts of my friend, Representative DINGELL, who has led the fight to extend Medicaid spousal impoverishment protections. Thanks to Representative DINGELL's advocacy, patients will be able to afford treatment and services without bankrupting their spouses.

Without this important protection, families would face a terrible choice between either unnecessary institutionalization or impoverishing themselves to ensure that their loved one receives the care that they need.

I would also like to thank Congressman UPTON for championing this important policy.

Second, my bill would provide additional funds to the successful Money Follows the Person demonstration. This funding will help more individuals transition from institutions to the communities they call home. I wanted to thank Representatives DINGELL and GUTHRIE for their advocacy on behalf of the patients and families who continue to benefit from this successful program.

Third, this bill includes the Advancing Care for Exceptional Kids Act, bipartisan legislation that gives States the flexibility to coordinate the most effective care for children with medically complex needs. The ACE Kids Act would not be possible without the sustained advocacy and hard work of Congresswoman CASTOR.

Representative CASTOR is an incredible advocate for some of our most vulnerable children and their families and has spent years championing this bill. I also want to thank my friend, Representative BILIRAKIS, for continuing to fight to ensure that our sickest kids have access to health homes.

Fourth, this bill contains important program integrity improvements to Medicaid, fixes that will save money and make Medicaid run more efficiently and effectively without sacrificing quality of care for patients.

That includes legislation championed by Representatives SCHRADER and WELCH to crack down on drug companies cheating the Medicaid program by not paying proper rebates on their drugs. The bill also gives the Department of Health and Human Services the tools it needs to hold ill-intentioned pharmaceutical companies accountable, while ensuring that patients who depend on these drugs continue to have access to them.

Fifth, and finally, this bill extends funding for the Excellence in Mental Health Act, so that people who are struggling with mental health and substance use disorders can continue receiving the treatment they need. The extension will help Congress find a longer-term solution so that this program can continue providing care to the people who need it.

I would like to thank Representative MATSUI for her continued hard work to support this demonstration. In brief, this bipartisan bill strengthens Medicaid by putting patients first. It was the approach I took as a doctor in the emergency department, and one I am continuing to take in Congress.

I know this bill will make our healthcare system stronger and more equitable, and I am proud to lead this critical effort.

I urge my colleagues to support the passage of H.R. 1839, the Medicaid Services Investment and Accountability Act of 2019, and I reserve the balance of my time.

Mr. BURGESS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to speak today in support of H.R. 1839, the Medicaid Services Investment and Accountability Act of 2019.

This is a bipartisan Medicaid extenders package that moves forward House priorities with responsible offsets. In fact, this package actually saves the Federal Government $1 million.

H.R. 1839 includes a new program to improve access to healthcare from medically complex children and reauthorizes important and effective programs that benefit Americans each and every day.

□ 1730

Money Follows the Person is an important program for the State of Texas. This Medicaid demonstration, which was established in 2005, has enabled eligible individuals in States across our Nation to receive long-term care services in their homes or other community settings, rather than an institution such as a nursing home.

While I am disappointed that H.R. 1839 includes only $20 million to extend this critical program through September instead of through the end of calendar year 2019, I am pleased that the funding for Money Follows the Person was ultimately included in this package.

This bill also includes an extension through September of the protection for Medicaid recipients of home and community-based services against spousal impoverishment program. This program specifically protects married individuals requiring Medicaid-covered and long-term services and supports to ensure that they do not have to deplete their financial resources or bankrupt themselves in order to become or remain Medicaid-eligible to receive such services. Our seniors are among our most vulnerable citizens, and it is programs such as this that will help protect them from financial ruin.

According to the National Institute of Mental Health, nearly one in five United States adults lives with a mental illness. Programs established to help individuals who are struggling with mental health issues, including the Excellence in Mental Health program, enable States to implement community behavioral health centers to address the needs of their populations. H.R. 1839 extends the Excellence in Mental Health program funding for Oregon and Oklahoma so that they will be on the same financial cycle as other States that are participating in the program.

The ACE Kids Act, which will improve care for children with complex medical needs, is also included in this package. The goal of this legislation is to improve comprehensive care for medically complex children through a State option to create a Medicaid health home specific to children. Health homes have proven effective in improving care coordination in the adult Medicaid population and hold promise for complex pediatric patients.

However, I want to clarify that this legislation is not intended to limit families or their physicians from selecting the provider of choice for medical services. There is nothing in this legislation that restricts the child's family or their physician from deciding who is best qualified as a Medicare provider. The Centers for Medicare and Medicaid Services has provided assurances that current freedom of choice rules will apply to new care coordination activity.

As a physician, I know that many children with chronic illnesses have a strong relationship with their physician and with other providers. I want to make certain that this new law will help families coordinate their care without affecting the relationship that families have with their current doctor or other medical care provider or other providers in their communities from whom they may wish to receive care.

This package contains must-pass provisions that will improve access for Medicaid beneficiaries, which is a laudable and important goal. Not only are these provisions imperative, but they are responsibly offset. In fact, this package saves money.

I would particularly like to thank the Energy and Commerce Committee staff, in particular J.P. Paluskiewicz and Caleb Graff, who have spent a significant amount of their lives negotiating this package to get it to the floor.

I support this legislation, and I urge other Members to continue to support this and get the other body to take it up and pass it as well.

Mr. Speaker, I reserve the balance of my time.

Mr. RUIZ. Mr. Speaker, I yield 3 minutes to the gentlewoman from California (Ms. MATSUI).

Ms. MATSUI. Mr. Speaker, I rise in support of the Medicaid Services Investment and Accountability Act of 2019 and the important provisions within this legislation to address mental health and addiction.

Every one of us knows someone who has struggled, is struggling, or will struggle with mental health issues. Whether it is a friend, a neighbor, or a family member, mental illness impacts all of us in some way.

Several years ago, we took a huge step forward to expand access to mental health services in communities across the Nation. The Excellence in Mental Health Act of 2014 was the culmination of years of hard work. At the same time, it was the largest Federal investment toward improving community-based mental healthcare.

That legislation allowed States to establish certified community behavioral health centers to ensure everyone who needs mental health services can receive them. These clinics have expanded mental health and substance use treatments dramatically, increasing access to 24-hour care, and they have been extremely successful in showing us how we can achieve real results in our communities.

Patients can receive medication-assisted treatment at almost every clinic. For many patients and providers, this is the first time that such services have been available in their communities, which are very often in medically underserved areas. Over half of these clinics now offer same-day access to care, which is so critical to those suffering from an acute mental health crisis.

I recently heard from a clinic in Oregon that will lose funding at the end of this week if Congress doesn't act now. This clinic has doubled the amount of time their doctors are able to spend with patients, has been able to hire more staff, and goes to meet patients in the community to better serve the unique needs of this population. We cannot afford to let this progress expire.

For far too long, those with mental illness have been left in the shadows, and mental health prevention and treatment have been left out of our health systems.

The mental health crisis in this country is very personal to me, and I have been fighting for patients and their loved ones for many years. I believe there is a lot we can do better to stop or slow down the hurt and pain patients and families feel when mental health is left unaddressed.

The bill before us today will extend this critical program in two States, Oregon and Oklahoma, until June and is a first step toward funding and expanding the program later this year.

There is a lot more we must do, and I look forward to continuing to work with my colleague, Representative MARKWAYNE MULLIN, to preserve this vital program.

Mr. BURGESS. Mr. Speaker, I yield such time as he may consume to the gentleman from Oregon (Mr. WALDEN), who is the Republican leader of the Energy and Commerce Committee.

Mr. WALDEN. Mr. Speaker, to my colleagues on both sides of the aisle, this is really important legislation we are working on today. H.R. 1839, the Medicaid Services Investment and Accountability Act of 2019, includes short-term extensions of several key Medicaid programs that have previously passed the House on a bipartisan basis.

I know our staffs on both sides of the aisle put a lot of time and effort into this, and I thank them all. I especially want to draw attention to Caleb Graff, who brought his own audience with him today in the gallery, his parents and brother. He has worked very hard on this, and we appreciate it.

I thank my chair and colleague, FRANK PALLONE of the Energy and Commerce Committee, for the partnership on this extenders package. Personally, I know a lot of us would have liked to have had these extended programs go out further to give beneficiaries and providers more certainty and more stability, and we will continue to put forth offers in good faith to work across the aisle to fund these critical parts of America's safety net.

However, we are here today up against a deadline, and I am pleased we were able to get at least through June and September, respectively, with these programs.

I am particularly pleased to see this package includes a short-term extension of the Excellence in Mental Health demonstration for my home State of Oregon. Both Oregon and Oklahoma were set to run out of funding at the end of this month, so this money will at least line them up with the other participating States whose funding expires at the end of June.

These eight State demonstration projects have shown promise as a way for community providers to expand access to treatment for mental and behavioral health, including addiction. As we continue our bipartisan work on the opioid crisis, which took more than 70,000 American lives in 2017 alone, Mr. Speaker, our behavioral health centers have the potential to provide real help. I have been encouraged to hear from providers in rural parts of my district, like Wallowa and Klamath Falls, about their success implementing this very program. I look forward to working on a longer term extension in the coming months.

The other Medicaid policies included in this bill are also very important.

The Money Follows the Person program is a demonstration program that helps transition individuals with chronic conditions and disabilities from institutions back into their local communities. That is where they can get the best care.

The so-called spousal impoverishment program protects seniors against the high costs of home and community-based services.

Finally, we are, once again, passing the ACE Kids Act here in the House, which was championed by our former colleague and chairman of the committee, Representative Joe Barton of Texas. It would improve the delivery of care for children with really complex medical conditions.

Mr. Speaker, I urge all our colleagues on both sides of the aisle to support this bipartisan package of healthcare bills.

The SPEAKER pro tempore. Members are reminded to avoid referencing occupants of the gallery.

Mr. RUIZ. Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. CASTOR).

Ms. CASTOR of Florida. Mr. Speaker, I thank my colleague and friend, Dr. RUIZ, for yielding the time.

Mr. Speaker, on behalf of families of children with complex medical needs—and there are many families like this all across America—I rise to urge approval of H.R. 1839, which includes a bill I have been working on for a number of years with my colleagues, including former Representative Joe Barton. It is called the ACE Kids Act.

We drafted the Advancing Care for Exceptional Kids Act a few years ago with a simple but important goal of putting children and their families first. The bill authorizes the creation of cost-saving and time-saving health homes where specialized care is coordinated in a high-quality setting.

Mr. Speaker, the children with complex medical conditions and their families are heroic, like Caroline West in my hometown of Tampa. She has a rare genetic condition, cerebral palsy, and a seizure disorder. She can't walk, and it is very difficult for her to speak, but she attends school part time and enjoys the life of a typical teenager, in many respects.

Lucy Ferlita is the only living person in the United States with early onset myopathy with areflexia, respiratory distress, and dysphagia. Very little is known about this disease, but we know that it is very difficult for her to eat. She has to have a feeding tube, a ventilator to breathe, and nursing care 24 hours a day.

Jaden Velasquez has a congenital heart defect.

Lakota Lockhart has a central nervous system disorder that causes him to not be able to breathe while he sleeps.

I met all of these kids back home in Tampa at St. Joseph's Children's Hospital. St. Joe's has a world-renown Chronic-Complex Clinic that was started 16 years ago by a compassionate pediatrician, Dr. Daniel Plasencia. This ACE Kids Act is modeled upon their work and the other good work being done at children's hospitals across this country.

The bill provides an incentive for States to establish health homes to

better coordinate care for kids with medical complexities. It also directs HHS to provide guidance to States on best practices.

Mr. Speaker, I urge my colleagues to adopt this bill with the ACE Kids Act included.

Mr. Speaker, I include in the RECORD a letter from a whole host of organizations thanking us for our leadership and for introducing this bipartisan legislation to improve care for children with complex medical conditions.

MARCH 25, 2019.

Hon. CHUCK GRASSLEY,
Washington, DC.
Hon. MICHAEL BENNET,
Washington, DC.
Hon. KATHY CASTOR,
Washington, DC.
Hon. GUS BILIRAKIS,
Washington, DC.
Hon. ANNA ESHOO,
Washington, DC.
Hon. JAIME HERRERA BEUTLER,
Washington, DC.

DEAR SENS. GRASSLEY AND BENNET, AND REPS. CASTOR, BILIRAKIS, ESHOO, AND HERRERA BEUTLER: As national organizations committed to children's health, we write in strong support of the ''Advancing Care for Exceptional Kids Act of 2019'' (ACE Kids Act, S. 317/H.R. 1226), which has been incorporated into the Medicaid Services Investment and Accountability Act of 2019 (H.R. 1839). We thank you for your leadership in introducing this bipartisan legislation to improve care for children with complex medical conditions in the Medicaid program.

Children with complex medical conditions have chronic life-limiting illnesses and disabilities, and often see six or more specialists and a dozen or more physicians. Under the current Medicaid system, parents of children with multiple, life-threatening disabilities struggle to coordinate the complex care of their kids, which often requires travelling to out-of-state providers. The ACE Kids Act works to create a patient-centered, pediatric-focused delivery system for this unique population of children. It is an important step in fixing the current fragmented system for children with complex medical conditions, ensuring ready access to care and reducing the burden on their families.

Under the ACE Kids Act, specially-designed health homes created for children with complex medical conditions will employ national quality standards and coordinate care—both essential to improving overall quality of care. These health homes will include the full range of acute, post-acute and primary care providers, and will focus on outpatient care to ensure children get the care that they need in the most appropriate setting closest to home while reducing unnecessary hospitalizations and emergency room visits. The ACE Kids Act—which is voluntary for states, families and providers—will also help families access the array of outpatient and community services and supports needed by these children.

Providing children with complex medical conditions enrolled in Medicaid the best possible care is a national challenge, and the ACE Kids Act will bring us closer to ensuring these vulnerable children receive the care they need. We are proud to support the ACE Kids Act, and we look forward to working with you to advance this critical legislation this year.

Sincerely,

American Academy of Pediatrics; American Association for Psychoanalysis in Clinical Social Work; American Association of Child and Adolescent Psychiatry; The American Board of Pediatrics; American College of Cardiology; American College of Surgeons; American Heart Association; American Physical Therapy Association; American Psychological Association; American Society of Echocardiography; American Thoracic Society; America's Essential Hospitals; Association of American Medical Colleges; Association of Medical School Pediatric Department Chairs; Autism Society of America; Autism Speaks.

Children's Cause for Cancer Advocacy; Children's Hospital Association; ChildServe; Epilepsy Foundation; Family Voices; March of Dimes; Maxim Healthcare Services; Mended Little Hearts; Moms Rising; National Association for Children's Behavioral Health; National Association of Pediatric Nurse Practitioners; National Board for Certified Counselors; National Down Syndrome Society; Pediatric Congenital Heart Association; Tricare for Kids Coalition; Vizient.

Mr. BURGESS. Mr. Speaker, I yield 3 minutes to the gentleman from Michigan (Mr. UPTON), who is the former chairman of the Energy and Commerce Committee and the author of the Cures for the 21st Century bill.

Mr. UPTON. Mr. Speaker, I rise in strong support of this bipartisan legislation.

I just want to remark briefly to my colleague from Florida (Ms. CASTOR) that the ACE Kids bill was a very important bill that we worked on actually for three Congresses. Joe Barton and the gentlewoman did a marvelous job. We didn't quite get it done. We passed it in this House with more than 400 votes in the last Congress. At the end, the Senate just didn't take it up.

It is very important that it is included as part of this bipartisan package, which we hope is early enough that we can get the Senate to act and pass it, because it really does impact families that are in much need.

I also am happy that we are moving this comprehensive bill today because it does contain a variety of important extensions. All of them had hearings and a lot of bipartisan support from the very first. This includes protections against spousal impoverishment for those seniors who have a spouse who is receiving home-based long-term care under Medicaid.

Back in 2010, we temporarily mandated these protections for home care, but that mandate was set to expire at the end of this very week, so it has to be extended.

Last year, my good friend and colleague, Mrs. DINGELL, and I introduced a bill to make the spousal impoverishment protections permanent, and we worked hard to get that done and passed here in this House. But at the end, even though we worked tirelessly on this, we got only a temporary extension. That is why it expires the end of this week.

This bill doesn't permanently extend it like we had hoped last year, but it does give a reprieve by extending the protection until the end of this year, so, in essence, a 9-month extension. It is my hope that we can use the time to actually pass a permanent extension.

I particularly commend the work of my colleague, Mrs. DINGELL from the great State of Michigan, for her passion on this, to make sure that we can get it done. I applaud the Speaker for getting it scheduled on the House floor early so that we can get it done, hopefully, this week, and the Senate can concur. Then let's use the time to really make it permanent, to help these families that otherwise will have funds taken out, as this really does rely on Medicaid, to a large degree.

□ 1745

Mr. RUIZ. Mr. Speaker, I yield 2 minutes to the gentlewoman from Michigan (Mrs. DINGELL).

Mrs. DINGELL. Mr. Speaker, I thank my colleague from California for his leadership on this issue and for yielding me time.

Mr. Speaker, I rise to speak in support of H.R. 1839, the Medicaid Services Investment and Accountability Act.

This bill includes two provisions that are very important to seniors and the disabled. It makes improvements, but, as you have heard my other colleagues talk about, not enough and not for long enough.

First of all, it has a provision that I worked on with my colleague, Mr. UPTON, that extends the spousal impoverishment protections for seniors in Medicaid through the end of the fiscal year. These critical protections ensure that individuals are not forced to spend down almost all of their resources and potentially go bankrupt to get the care that they need. No American should be forced into poverty just to receive adequate healthcare.

In addition, this bill contains a provision that I worked on with my colleague, Mr. GUTHRIE, to extend the highly successful Money Follows the Person program, again, just through the end of the fiscal year. This program provides grants to States to help individuals voluntarily transition from an institutional setting to a community care setting, their own home. All Americans, regardless of income, deserve to receive long-term care in a setting that they prefer.

While I am pleased that these programs will be extended through the end of September and not allowed to lapse—and that is critical—this is only a partial victory. Both the Money Follows the Person program and spousal impoverishment protections need to be extended for the long term, not a few months at a time. We keep doing that. It was 3 months ago that we just extended it for 3 months.

Seniors and individuals with disabilities need to have security. They need to know and have peace of mind that these important provisions are going to be there for the long term. And States need stability and certainty in order to fully implement these efforts.

Mr. BURGESS. Mr. Speaker, I yield 2 minutes to the gentleman from Kentucky (Mr. GUTHRIE), a valuable member of the Energy and Commerce Committee and the Republican leader of the Oversight and Investigations Subcommittee.

Mr. GUTHRIE. Mr. Speaker, I rise today in support of H.R. 1839, which extends the important Medicaid Money Follows the Person program until September.

The Medicaid Money Follows the Person program allows certain Medicaid beneficiaries, such as the elderly or individuals with disabilities, to transition from a healthcare facility to receiving care in their own homes. It does not force patients to leave a facility if they don't want to.

Since the Money Follows the Person program was created over a decade ago, it has successfully helped over 88,000 individuals receive care in their own homes.

I have worked with Congresswoman DEBBIE DINGELL on the bipartisan EMPOWER Care Act, which extends the Medicaid Money Follows the Person program for 5 years.

I urge my colleagues to support H.R. 1839 to extend the program until September, and I will continue to work with Congresswoman DINGELL to get the EMPOWER Act across the finish line.

Mr. RUIZ. Mr. Speaker, I am ready to close.

Mr. Speaker, I urge my colleagues to support this bipartisan bill, H.R. 1839. I really thank all the Members who put their heart and soul into their pieces of legislation. I thank the staff of the Energy and Commerce Committee, both Democratic and Republican, who have come together to work to plug a hole, to fill in the cracks, and to make sure that services continue, that value is given, and that healthcare puts our patients first, our kids first, so that we can give them the appropriate care that they deserve, no matter where they are from or whether or not they can afford it.

This is why I am so humbled to carry the water on this bill. On behalf of myself, my staff, and my office, I thank everybody involved in this bill.

Mr. Speaker, I urge support for this bipartisan bill, H.R. 1839, and I yield back the balance of my time.

Mr. BURGESS. Mr. Speaker, this is an important bill, and I urge all Members to support it.

Once again, I want to single out and thank J.P. Paluskiewicz and Caleb Graff for really moving heaven and earth to get this to the floor so that these valuable programs do not lapse.

Mr. Speaker, I yield back the balance of my time.

Ms. JOHNSON of Texas. Mr. Speaker, I rise today to voice my support for H.R. 1839, the Medicaid Services Investment and Accountability Act of 2019.

This bill would extend programs that help seniors and people with disabilities live in the community, rather than institutions. It would extend the authorization of the Excellence in Mental Health demonstration so that none of the participating states run out of critical funds. It would authorize additional program integrity measures in the Medicaid Drug Rebate Program and in other areas of the Medicaid program. Finally, it would provide states with the option to provide coordinated care for children with medically complex conditions.

As representatives of Americans from all corners of our country, we have a responsibility to protect and enhance Medicaid, a vital safety net program that finances the delivery of care to 69 million people in this country. Without this program, the quality and access of healthcare for our most vulnerable populations will be at risk. We must ensure that future generations are able to receive the necessary health benefits to live full and prosperous lives.

On behalf of the over four and a half million Medicaid beneficiaries in my home state of Texas, I am proud to support the Medicaid Services Investment and Accountability Act of 2019.

I urge my colleagues to support this bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. RUIZ) that the House suspend the rules and pass the bill, H.R. 1839, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. BURGESS. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

The point of no quorum is considered withdrawn.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess until approximately 6:30 p.m. today.

Accordingly (at 5 o'clock and 52 minutes p.m.), the House stood in recess.

□ 1830

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. LOWENTHAL) at 6 o'clock and 30 minutes p.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Proceedings will resume on motions to suspend the rules previously postponed.

Votes will be taken in the following order:

H.R. 1616, by the yeas and nays; and

H.R. 1839, de novo.

The first electronic vote will be conducted as a 15-minute vote. Pursuant to clause 9 of rule XX, any remaining electronic vote will be conducted as a 5-minute vote.

EUROPEAN ENERGY SECURITY AND DIVERSIFICATION ACT OF 2019

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the unfinished business is the vote on the motion to suspend the rules and pass the bill (H.R. 1616) to prioritize the efforts of and enhance coordination among United States agencies to encourage countries in Central and Eastern Europe to diversify their energy sources and supply routes, increase Europe's energy security, and help the United States reach its global energy security goals, and for other purposes, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SIRES) that the House suspend the rules and pass the bill, as amended.

The vote was taken by electronic device, and there were—yeas 391, nays 24, not voting 16, as follows:

[Roll No. 126]

YEAS—391

Adams
Aderholt
Aguilar
Allred
Amodei
Armstrong
Arrington
Axne
Babin
Bacon
Baird
Balderson
Banks
Barr
Barragán
Bass
Beatty
Bera
Bergman
Beyer
Bishop (GA)
Bishop (UT)
Blumenauer
Blunt Rochester
Bonamici
Bost
Boyle, Brendan F.
Brady
Brindisi
Brooks (IN)
Brown (MD)
Brownley (CA)
Buchanan
Bucshon
Budd
Burgess
Bustos
Butterfield
Byrne
Calvert
Carbajal
Cárdenas
Carson (IN)
Carter (GA)
Carter (TX)
Cartwright
Case
Casten (IL)
Castor (FL)
Castro (TX)
Chabot
Cheney
Chu, Judy
Cicilline
Cisneros
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Cole
Collins (GA)
Collins (NY)
Comer
Conaway
Connolly
Cook
Cooper
Correa
Costa
Courtney
Cox (CA)
Craig
Crawford
Crenshaw
Crist
Crow
Cuellar
Cummings
Cunningham
Curtis
Davids (KS)
Davidson (OH)
Davis (CA)
Davis, Rodney
Dean
DeFazio
DeGette
DeLauro
DelBene
Delgado
Demings
DeSaulnier
DesJarlais
Deutch
Diaz-Balart
Dingell
Doggett
Doyle, Michael F.
Duffy
Emmer
Engel
Escobar
Eshoo
Espaillat
Estes
Evans
Fitzpatrick
Fleischmann
Fletcher
Flores
Fortenberry
Foster
Foxx (NC)
Frankel
Fudge
Fulcher
Gabbard
Gallagher
Gallego
Garamendi
García (IL)
Garcia (TX)
Gianforte
Gibbs
Gohmert
Golden
Gomez
Gonzalez (OH)
Gonzalez (TX)
Gooden
Gottheimer
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Green (TN)
Green (TX)
Grothman
Guest
Guthrie
Haaland
Hagedorn
Harder (CA)
Hartzler
Hastings
Hayes
Heck
Hern, Kevin
Herrera Beutler
Hice (GA)
Higgins (LA)
Higgins (NY)
Hill (AR)
Hill (CA)
Himes
Holding
Hollingsworth
Horn, Kendra S.
Horsford
Houlahan
Hoyer
Hudson
Huffman
Huizenga
Hunter
Hurd (TX)
Jackson Lee
Jayapal
Jeffries
Johnson (GA)
Johnson (OH)
Johnson (SD)
Johnson (TX)
Joyce (OH)
Joyce (PA)
Kaptur
Katko
Keating
Kelly (IL)
Kelly (MS)
Kelly (PA)
Khanna
Kildee
Kilmer
Kim
Kind
King (IA)
King (NY)
Kinzinger
Kirkpatrick
Krishnamoorthi
Kuster (NH)
Kustoff (TN)
LaHood
LaMalfa
Lamb
Lamborn
Langevin
Larsen (WA)
Larson (CT)